MHSOAC
Mental Health Services
Oversight & Accountability Commission

Research and Evaluation Committee Meeting

August 17, 2022
9:00 am to 12:00 pm

Chair Itai Danovitch
Vice Chair Steve Carnevale

Research and Evaluation Committee Meeting/Teleconference Agenda

Wednesday, August 17, 2022, 9:00 AM – 12:00 PM

Link to meeting: https://mhsoac-ca-gov.zoom.us/j/88173750788
Call-in Number: 669-900-6833, 408-638-0968
Meeting ID: 881 7375 0788
Password: No password, Waiting room access
Note: The meeting audio will be recorded.

Meeting Location:
Mental Health Services Oversight & Accountability Commission Office
1812 9th Street, Sacramento CA 95811

Additional Meeting Locations

Cedars-Sinai Medical Center
8700 Beverly Blvd.
Los Angeles, CA 90048

Children's Hospital LA
5000 Sunset Blvd., 5th Floor
Los Angeles, CA 90027

World Financial Center
19112 Gridley Rd., Ste 224
Cerritos, CA 90703

OC Health Care Agency
405 W. 5th Street
Conference Room 205
Santa Ana, CA 92701

Meeting purpose and goals:

- Provide an update on the Commission's Research and Evaluation Division activities, including planning the evaluation of the Mental Health Student Services Act (MHSSA).
- Advise the Commission on the formative/process and summative evaluations of the S.B. 82 Triage Grant programs.

Public Notice: All meeting times are approximate and subject to change. Agenda items are subject to action by the MHSOAC and may be taken out of order to accommodate speakers and to maintain a quorum, unless noted as time specific. Pursuant to the Americans with Disabilities Act, individuals who, because of a disability, need special assistance to participate in a Mental Health Services Oversight and Accountability Commission or Committee Meeting may request assistance by emailing the MHSOAC at mhsoac@mhsoac.ca.gov. Requests should be made one week in advance whenever possible.

TIME	TOPIC	Agenda Item
9:00 AM	**Welcome** *Commissioners Dr. Itai Danovitch, Chair & Mr. Steve Carnevale, Vice Chair* Welcome, opening remarks and review of the agenda.	
9:10 AM	**Action: Approval of Meeting Minutes** *Commissioner Dr. Itai Danovitch, Chair* The Research and Evaluation Committee will consider approval of the minutes from the May 12, 2022 meeting teleconference. • **Public comment** • **Vote**	**1**
9:20 AM	**Information: Status Report on the Commission's Research and Evaluation Portfolio** ***Presenter:*** *Melissa Martin-Mollard, PhD, Director of Research and Evaluation* The Director of Research and Evaluation at the Commission will provide update on: (1) The Research and Evaluation Division's projects and activities for the second quarter; and (2) The MHSSA evaluation. She will explain how feedback received from the Committee and public at the May Research and Evaluation Committee meeting has been used to inform evaluation planning.	**2**
9:40 AM	**Information and Discussion: Update on the Commission's Evaluation of S.B. 82/833 Triage Grant Programs** ***Presenters:*** *Corey O'Malley, PhD, Postdoctoral Researcher Semel Institute for Neuroscience and Human Behavior, UCLA* *Mark Saville, PhD, Assistant Professor, Department of Psychiatry, UC Davis* *Kallie Clark, PhD, Triage Evaluation Project Director, MHSOAC* Presenters will provide an update on the formative/process and summative evaluations of the Triage Grant programs, which will include a summary of community engagement, progress implementing the evaluation plan, preliminary findings and lessons learned, and next steps. **Question and Answers**	**3**
10:30 AM	**Break**	

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TIME	TOPIC	Agenda Item
10:40 AM	***Continuation of Agenda Item #3*** Finish presentations and Q & A. **Breakout group discussion:** There will be three (3) breakout groups that the Committee and members of the public will be able to choose to participate in for an in-depth discussion of the Triage evaluations: • Group 1: Implementation evaluation of child/school Triage programs. • Group 2: Implementation evaluation of adult/TAY Triage programs. • Group 3: Preliminary analyses for evaluation of client outcomes for Triage programs. Each group will have a specific set of questions to guide discussion and elicit member insight and feedback (Please see the meeting packet). Overarching questions for all groups to consider include: • How can the Commission ensure that the Triage evaluation findings are meaningful and actionable? • How can the evaluation findings best be leveraged to inform local programs and state policy?	**3**
11:30 AM	**Breakout Groups Report Out** *Commissioner Dr. Itai Danovitch, Chair* **Public Comment**	
11:50 AM	**Wrap-Up** *Commissioners Dr. Itai Danovitch, Chair & Mr. Steve Carnevale, Vice Chair*	
12:00 PM	**Adjourn**	

AGENDA ITEM 1

Action

Approval of May 12, 2022 Meeting Minutes

August 17, 2022 Research and Evaluation Committee Meeting

Summary: The Commission's Research and Evaluation Committee will review the minutes from the May 12, 2022 Committee teleconference meeting. Any edits to the minutes will be made and the minutes will be amended to reflect the changes and posted to the Commission Web site after the meeting.

Presenter: None

Enclosures (1): May 12, 2022 Meeting Minutes.

Proposed Motion: The Committee approves the May 12, 2022 meeting minutes.

Research and Evaluation Committee Teleconference Meeting Summary
Date: Thursday, May 12, 2022 | Time: 9:00 a.m. – 12:00 p.m.

MHSOAC
1812 9th Street
Sacramento, CA 95811

Additional public locations included North Berkeley Library, 1170 The Alameda, Berkeley, CA 94707; Pacific Clinics, 251 Llewelyn Ave, Campbell, CA 95008; World Financial Center, 19112 Gridley Rd., Ste 224, Cerritos, CA 90703; Cedars-Sinai Medical Ctr, Thalians Health Center, 8730 Alden Drive, Los Angeles, CA 90048; Live & Learn, Inc., 1163 Main Street, Morro Bay, CA 93442; Stanford Sierra Youth & Families, 8912 Volunteer Lane, Sacramento, CA 95826; UC Davis Medical Center, 2315 Stockton Blvd, Sacramento, CA 95817; UCD Center for Reducing Health Disparities, 2921 Stockton Blvd, Ste 1408, Sacramento, CA 95817; Noe Café, 1299 Sanchez St., San Francisco, CA 94114; OC Health Care Agency, 405 W. 5th Street, Conference Room 512, Santa Ana, CA 92701; Rand Corp., 1776 Main Street, Santa Monica, CA 90407; New York Athletic Club, 180 Central Park South, New York, NY 10019

****DRAFT****

Committee Members:	Staff:	Other Attendees:
Steve Carnevale, Vice Chair Rikke Addis Sergio Aguilar-Gaxiola Eleanor Castillo Sumi Sharon Ishikawa Bridgette Lery Gustavo Loera April Ludwig Belinda Lyons-Newman Ruth Shim Katherine Watkins	Toby Ewing Maureen Reilly Latonya Harris Kai LeMasson Tom Orrock Sheron Wright	Steve Leoni Steve McNally

Committee members absent: Itai Danovitch, Chair, Robert Brook, , Jonathan Freedman, Laysha Ostrow, Mari Radzik, and Lonnie Snowden, Jr.

Welcome

Commissioner Steve Carnevale, Committee Vice Chair, called the meeting to order at approximately 9:00 a.m. and welcomed everyone. He reviewed the meeting protocols and meeting agenda. Today's meeting objectives were to provide an update on the Commission's Research and Evaluation Division activities and the Committee's advisory role, accomplishments, and next term, and to advise the Commission on the evaluation of the Mental Health Student Services Act (MHSSA).

Agenda Item 1: Approval of Meeting Minutes

Maureen Reilly, Acting Chief Counsel, called the roll and confirmed the presence of a quorum.

Agenda Item 1: Action – Approval of Meeting Minutes

Vice Chair Carnevale asked for a motion to approve the meeting minutes for the February 16, 2022, Research and Evaluation Committee teleconference meeting.

Committee Member Aguilar-Gaxiola made a motion to approve the minutes as presented. The motion was seconded by Committee Member Shim.

Vote recorded with participating members as follows:

- Approve: Committee Members Addis, Aguilar-Gaxiola, Castillo Sumi, Ishikawa, Lery, Loera, Ludwig, and Shim, and Vice Chair Carnevale.
- Abstain: Committee Members Lyons-Newman and Watkins.

Agenda Item 2: Information – Status Report on the Commission's Research and Evaluation Portfolio

Presenter:

- Toby Ewing, Ph.D., Executive Director

Vice Chair Carnevale stated the Committee will hear a status update on the Commission's Research and Evaluation Division projects and activities. He asked staff to present this agenda item.

Toby Ewing, Ph.D., Executive Director, reviewed the Activities Summary and Guide of the Research and Evaluation Division Activities engaged in this past quarter, which was included in the meeting materials. He stated the Commission's work in research and evaluation is done in five areas: tracking community indicators, curating mental health resources, policy research to improve policies and practices, evaluating new initiatives to accelerate learning, adaptation, and scaling, and building data infrastructure to support accountability.

Vice Chair Carnevale thanked Committee Members for their service, investment of time and energy, and commitment to the Committee's success. He highlighted Committee activities and accomplishments since August of 2020, when the Committee first convened. He stated staff has contacted all Committee Members to gather their thoughts and perspectives on the Committee with the following results:

- Most members have agreed to continue serving on the Committee.
- One member has taken on new projects and will be leaving the Committee.
- Committee Members indicated that a better use of Committee Members' time would be to serve on work groups to take a deeper dive into projects and to work on something tangible.

Vice Chair Carnevale stated ideas and suggestions are being considered; a plan for next term will be presented at the next Committee meeting. Committee Members who are not seeking reappointment to the Committee are to email staff by May 31st.

Discussion

Committee Member Loera asked about reasons for the disconnect with getting county services, such as stigma.

Executive Director Ewing stated this question reflects the complexity of the system, the lack of shared information and understanding, and how the systems were designed. He stated he was recently on a panel with Senator Umberg, Mayor Goh from Bakersfield, and Mayor Steinberg from Sacramento. Senator Umberg pointed out that family members often do not know what to do for unmet mental health needs and it is unclear how to get the help they need. Even if they do know what they are looking for, the service delivery system is difficult to navigate.

Executive Director Ewing stated in other areas of health care it is easier to understand what is needed and how to navigate the system because there are well-known and clear pathways to care, typically through the primary care physician or a health clinic. These conversations are not seen in other areas of health care and they need to be addressed. It is also important to learn why it is difficult to understand mental illness and mental health care needs, and to have a clear understanding of what is available and what is appropriate.

Executive Director Ewing stated Committee Member Loera's question touches on a several issues, one of which is stigma, but there are other conversations about racism, bias, discrimination, differences of agreement on issues, and the lack of culturally-competent and language-appropriate care. This begs the question of why individuals do not participate when care is available. Individuals who are not interested in accessing care are often defined as care-resistant.

Executive Director Ewing stated yesterday's panel also discussed the work that must be done to make it easier to engage the public in ways that reflect a high level of trust, including issues around law enforcement involvement in mental health care delivery.

Committee Member Aguilar-Gaxiola echoed Committee Loera's concerns and thanked Executive Director Ewing for his excellent overview of the issues. He asked that it be shared in writing to Committee Members.

Committee Member Aguilar-Gaxiola agreed that stigma prevents individuals who have been impacted by it from seeking services. He also agreed with the importance of trust and stated the need for the MHSOAC, community-based organizations, and public agencies to be trustworthy. Trust is of critical importance for populations such as farm workers and many others who have been underutilizing services or not seeking services for decades. Trust plays a key role when individuals from those communities finally do seek services.

Committee Member Aguilar-Gaxiola stated the National Academy of Medicine has been working for over three years on assessing meaningful community engagement measures in health and health care and has done an in-depth literature review. Community indicators such as trust, sharing community power, diversity, inclusion, etc. are of critical importance.

Executive Director Ewing stated the Commission's work in the area of tracking community indicators is to locate information that is both available and applicable. This is difficult to do because the culture of data sharing is constrained. The behavioral health community

needs to get better at clarifying expectations on the community indicators needed, the level of detail of data that is necessary, and how to pull that information out of closed databases and put it online.

Executive Director Ewing stated the Commission's first work was simply on Mental Health Services Act (MHSA) dollars. Although this work is valuable, has taken years, and is ongoing, it does not translate into lower teen suicide rates or improved employment or housing outcomes. It takes three years for the state to release data on suicidal behavior. Three-year-old data on suicide is helpful for historical analysis but is not helpful for day-to-day changes in policies and practices to save lives. He contrasted this to how quickly the world was able to marshal COVID data with daily reports on global vaccination rates.

Executive Director Ewing stated the community has a tremendous amount of work to do to elevate the importance of data and to make it available in ways that support accountability and programmatic and policy decision-making.

Agenda Item 3: Information – The Commission's Evaluation of the Mental Health Student Services Act (MHSSA)

Presenters:

- Tom Orrock, Chief of Stakeholder Engagement and Grants
- Latonya Harris, Ph.D. Research Scientist
- Cheryl Ward, Health Program Specialist

Vice Chair Carnevale stated the Committee will hear an overview of the MHSSA grant program implementation and discuss draft research questions to guide evaluation of the MHSSA. He asked staff to present this agenda item.

Tom Orrock, Chief of Stakeholder Engagement and Grants, stated staff has been hard at work to get funds out to nearly every county in the state so that partnerships between behavioral health departments and school districts can be formed or, in some cases, strengthened in order to bring a more coordinated approach to school-based mental health services to students around the state. He provided an overview, with a slide presentation, of the background, funding, goals, survey results, and the learning collaborative. He stated the learning collaborative provided an excellent opportunity to collect data on lessons learned, challenges, successes, and barriers. One of the biggest challenges impacting program implementation was limited workforce issues.

Latonya Harris, Ph.D., Research Scientist, continued the slide presentation and discussed key considerations, challenges, and opportunities. She stated today's meeting gives an opportunity for the Committee to provide guidance for the MHSSA evaluation. She asked Committee Members to refer to the Draft Categories and Guiding Research Questions for the Evaluation of the MHSSA Act document, which was included in the meeting materials. The key questions for breakout group discussion were as follows:

1. What priorities should the Commission take into consideration as it pursues this work if it hopes to provide information and analysis that will be important to meeting the mental health needs of students?
2. Are there examples of evaluative strategies or reporting frameworks that lend guidance to this work?

Agenda Item 1: Approval of Meeting Minutes

3. How can the Commission best weigh trade-offs among these diverse audiences and its capacity to meet their information needs?

Committee Member Feedback

- Design the evaluation strategy to focus on schools with common denominators across all counties, since every county has a public school system and every child is required to go to school.
    - Possible data points include the number of school counselors, the length of time it takes to get an IEP, and whether there are school mental health programs or groups run by psychologists for children.
- Equip teachers to better recognize early warning signs and early identification of what can potentially become a severe mental health issue without making them social workers.
- Involve children in creating the title of the MHSSA program in their school.
- Compare the total number of school districts in the county, the number of school districts within each county that participated in the MHSSA, the number of students who were impacted, the types of resources that were available, and how those resources were used.
- The operative phrase in Key Question #1 is "the mental health needs of students." Keep up-to-date on what that means, how it can be measured, and how teachers can be made more aware of warning signs.
- Define "student" and the age-range of the student population.
- Create a pipeline for students to become behavioral health professionals to help meet the need during this national mental health crisis.
- Recognize that the school system is a separate system.
- Connect with students effectively where they are to provide meaningful outreach and services that they need that are not already being provided by the school.
- Learn to understand the factors or characteristics that might impede or enhance collaborations between the behavioral health system and the learning institutions.

Committee Member Castillo Sumi stated the National Center for School Mental Health has a SHAPE Assessment, which gives a baseline for resources in the school district and in the state, points out gaps, and compares California with the rest of the country.

Committee Member Aguilar-Gaxiola stated the California Future Health Workforce Commission published a report with recommendations on student mental health needs.

Break

Agenda Item 3: Breakout Groups (Continuation of Agenda Item #3)

Vice Chair Carnevale asked Committee Members and members of the public to break out into small groups for an in-depth discussion of the MHSSA evaluation and to use the handout for Agenda Item #3 as a reference during the discussion.

Breakout Groups Report Out

Committee Members reconvened and Vice Chair Carnevale asked the breakout groups to summarize the feedback received during the group session.

Agenda Item 1: Approval of Meeting Minutes

The groups summarized their comments and suggestions as follows:

Group 1

Question 1

- Have data on multiple levels. From the student level, use currently-available tools to help understand whether or not the mental health needs of students are known.
- Have multiple levels of evaluation from individual to the state system.
- Understand the types of available services and the communication between students and the schools around this initiative, including from the state to families.
- There is a need for real-time data.
- Be cautious about asking to see evidence within the first year. Be mindful, when looking at the data, that there are things that might not be seen immediately.

Question 2

- Build on what is currently out there such as the National Center for School Mental Health.
- Take into consideration other systems such as CalAIM.
- Define the scope of the evaluation.

Question 3

- Make sure we have confidence in the data that is available, especially data that will be used for decision-making.
- Have clarity around the same terminology with different contexts whether it is in school or behavioral health – they might have different meanings. Be cognizant of that in any of the different reports.
- Have separate reports for the different audiences.
- Have technical assistance for different languages or different definitions out there. There seems to be two different systems.

Group 2

Question 1

- Consider equity, equity distribution, and accessibility for services.
- Determine the communication strategy for these programs and for the findings. Prioritize getting information to students and families in a way that they can use it.
- Look at existing services and models, including models that engage student ambassadors and embed peer supports, such as career technical education and organizations in schools, which already prepare students for professions in areas such as social work, psychiatry, and psychology.
- Look at existing models already in community schools.

Agenda Item 1: Approval of Meeting Minutes

Question 2

- Drive everything from a theory of change. What is our theory of change?
- Before getting to methodologies and questions of how, first back up and ask why.
- Have a model to think about process, quality, and capacity and think about the area outcomes fall into. That could drive how to evaluate those and what the best methodologies are.
- Start with what is expected to be seen and work backwards from there.

Question 3

- Be honest with information up front.
- Identify key indicators and use dashboards to make information easily accessible.
- Use narratives and digestible information that has meaning for families and students so they will internalize them and therefore use the information that is provided to them.

Group 3

Question 1

- Focus on outcomes for different populations such as BIPOC and intersectional identities.
- Focus on preschool where issues begin and on into the prison pipeline.
- Put the responsibility on the school system and not just on the students.
- Look broadly across the state at structure, process, and outcomes, and look at building blocks and if there are enough staff room and services onsite.
- Focus on public schools as they are universal. Put de-escalation practices in place.
- Vigorously close gaps for services each school has or does not have.
- Look at neurodiversity.
- An example of a good model would be to look at good outcomes over 40 years and measure social determinants of health with a way to detect changes and outcomes over time.
- Focus on longitudinal evaluations and set up schools that way.

Question 2

- Focus on qualitative research and look at the basic relationship and not just simply a satisfaction survey.
- Build trust across systems and assess if those structures are formalized or not.
- Consider whether schools are trauma-informed and if their approaches are nonpunitive.

Question 3

Agenda Item 1: Approval of Meeting Minutes

- Invest in pushing increasing data capacity such as AI, for example, in meeting information needs from diverse groups in the most efficient and effective ways.
- Look at funding and the intersection of funding and find commonalities across groups, but also look into models where it is not just one size fits all.
- Make sure that communication is diverse and that it is meaningful to all audiences at different levels.
- Look at the capacity of companies that are able to bridge the gap in data sharing across entities and their accessibility to tailored approaches.

Public Comment

Steve McNally, thanked the Commission for their commitment to keep meetings on Zoom for better public participation statewide.

Wrap-Up

Executive Director Ewing thanked everyone for giving of their valuable time. He stated appreciation for the enthusiasm for the work and the clear expectations that the community will get better at meeting the behavioral health needs of children, youth, and families. This needs to be a persistent, overarching value in all the work. He thanked Committee Members for their guidance in how to make that happen.

Adjourn

Vice Chair Carnevale stated the next Committee meeting will be held in August. He thanked everyone for their participation and feedback and adjourned the meeting at approximately 12:00 p.m.

AGENDA ITEM 2

Information

Status Report on the Commission's Research and Evaluation Portfolio

August 17, 2022 Research and Evaluation Committee Meeting

Summary: The MHSOAC's Director of Research and Evaluation, Dr. Melissa Martin-Mollard will provide a status update on projects and activities outlined in the Research and Evaluation Strategic Portfolio. Dr. Martin-Mollard will focus her report-out on the evaluations of the Mental Health Student Services Act (MHSSA) grant programs and the S.B. 82/833 Mental Health Crisis Triage grant programs. She also will discuss the next phase of the Research and Evaluation Committee and the establishment of a Committee Workgroup to support MHSSA evaluation planning.

Background: The MHSOAC's Research and Evaluation Strategic Portfolio organizes the division's activities into five primary, interrelated activities that support the Commission's mission. The Research and Evaluation Committee provides guidance and expertise to the Commission in implementing the portfolio, with a focus on children/youth and legislatively mandated evaluations (e.g., MHSSA, S.B. 82/833 Triage).

At the May 12, 2022 Research and Evaluation Committee meeting, Commission staff presented an overview of the Mental Health Student Services Act (MHSSA) grant program implementation and facilitated a discussion about key considerations to guide data reporting and monitoring of the MHSSA. Dr. Martin Mollard will summarize the feedback received from the Committee and members of the public on May 12, 2022 and discuss how it is being incorporated into MHSSA evaluation planning and next steps.

Lastly, the Committee completed its two-year term (August 2020-August 2022) and has been extended by the Chair, Dr. Itai Danovitch. Twelve of the original 16 Committee members have committed to continuing to serve on the Committee. Dr. Melissa Martin-Mollard will discuss the Committee's next phase, which includes the formation of a MHSSA Workgroup. The workgroup will provide expert guidance to Commission staff regarding MHSSA evaluation planning and implementation.

Presenter: Melissa Martin-Mollard, PhD, Director of Research and Evaluation

Enclosures (2): (1) MHSOAC Research and Evaluation Portfolio; and (2) MHSOAC Research and Evaluation Activities Summary and Guide (abbreviated 1-page portfolio).

Handouts (1): PowerPoint presentation.

Mental Health Services
Oversight & Accountability Commission

RESEARCH AND EVALUATION PORTFOLIO

MAY 2022 UPDATE

I. Tracking Community Indicators

The Commission tracks community mental health indicators to support understanding of opportunities, challenges, and pathways to improved outcomes.

The Commission currently reports on its website the following information:

- Mental Health Services Act (MHSA) funding, expenditures and balances.
- Criminal justice involvement for people with mental health needs.
- Number of people served in county mental health programs.
- Participation in Full Service Partnerships – a form of intensive community-based services.
- Information on suicide.
- Demographic disparities in access to county behavioral health services.

In addition to updating those dashboards as new information is available, the Commission is working on the following initiatives:

- Innovation Investments. The Commission is previewing an innovation dashboard that allows the public to track innovation investments by county, area of focus and status.

- Innovation Revenues. The Commission is previewing a tool to allow counties and the public to view existing innovation investments and currently available revenues. Discussions are underway to explore the viability of forecasting future innovation revenues to facilitate improved innovation planning.

- Expanding Demographic Data Relating to Suicide. The Commission is exploring opportunities to release detailed demographic data relating to suicide.

- County Spending on Full Service Partnerships. The Commission is analyzing county spending on Full Service Partnerships and comparing that information against minimum expenditure requirements outlined in the law.

- MHSA Prudent Reserves. The Commission is documenting prudent reserve balances held by county mental health programs to increase public understanding of revenue volatility and strategies to address fiscal risks.

II. Curating Community Mental Health Resources

The Commission gathers information from county mental health plans and shares that information publicly to support broad public understanding of the availability of mental health services in communities statewide.

The Commission is working on the following initiatives:

- Documenting Innovation Projects. The Commission is building a data dashboard to display high-level information on current Innovation projects, including information on the location on projects, target populations, and project descriptions.

- Building a Prevention and Early Intervention Dataset. The Commission is analyzing information on county prevention and early intervention projects to explore and document patterns in county investments, their goals and anticipated outcomes. Data are being validated for FY16/17 along with budget and expenditure data for FY16/17 through FY19/20.

III. Policy Research to Improve Policies and Practices

The Commission undertakes policy and related research to understand what is working, what is not and opportunities for improvement. Based on that work, the Commission provides guidance to the Governor and Legislature on strategies to improve California's mental health system and the outcomes it supports.

The Commission recently released policy recommendations on school mental health and suicide prevention. Earlier reports covered fiscal reversion and strategies to reduce criminal justice involvement among mental health consumers. Work is underway to implement the recommendations in those projects.

The Commission is currently working on the following initiatives:

- Mental Health in the Workplace. Senate Bill 1113 (Monning) in 2018 directed the Commission to establish a framework and voluntary standards for promoting mental health in the workplace. The standards for workplace mental health are intended to reduce mental health stigma, increase public, employee, and employer awareness of the significance of mental health, and create avenues to treatment, support, and recovery.

- Prevention and Early Intervention. Senate Bill 1004 (Wiener, 2018) directed the Commission to establish priorities for prevention and early intervention investments. This project is identifying strategic opportunities for those investments to improve mental health and related outcomes. The project includes the development of data monitoring and technical assistance strategies to improve prevention and early intervention opportunities.

IV. Evaluating New Initiatives to Accelerate Learning, Adaptation, and Scaling

The Commission conducts program evaluations in response to statutory direction and to support its broad mission.

Agenda Item #2: Status Report on Commission's Research & Evaluation Portfolio

The following evaluations are underway:

- Mental Health Student Services Act. The Commission has invested more than $200 million to fund partnerships between county mental health programs and local education agencies to support school mental health. Funds have been released to partnerships in 54 counties to support a range of needs. The Commission is currently negotiating access to data, exploring evaluation questions, and designing an evaluative approach.

- SB 82/Investment in Mental Health Wellness Act. The Commission has released $83 million in grants to 20 counties to improve county response to mental health crises. The Commission has contracted with the University of California, Davis and the University of California, Los Angeles to conduct formative and process evaluations of these Triage investments. The Commission is working with a team from the University of California, San Francisco to conduct a summative evaluation of these investments.

- Innovation Incubator. In 2019, the Commission released $5 million in grants to facilitate multi-county collaboration on innovations to reduce the justice involvement of mental health clients. Funds support a range of initiatives. Commission staff have conducted 26 key informant interviews to better understand

- Full Service Partnerships. As required under Senate Bill 465 (Eggman), the Commission will report biennially (beginning in November 2022) on outcomes (e.g., incarceration, hospitalization, and homelessness) for individuals receiving community mental health services under a Full Service Partnership model.

V. Building Data Infrastructure to Support Accountability

To support the Commission's research and evaluation work, it negotiates data sharing agreements and is building the data infrastructure to link mental health data to other high-value data sets, including education, employment, criminal justice, public health, and related data.

The Commission currently has data sharing agreements in place with the following agencies:

- California Department of Education. The Commission recently obtained datasets from the California Department of Education for consumers of MHSA funded services including student demographics, 4 year-adjusted graduation rates, student attendance, student discipline, and assessment data. These data will be used to establish a school performance profile and assess outcomes of students who have received community mental health services.

- California Department of Justice. The Commission has Department of Justice data that includes demographics, arrests, type of charge, disposition, and disposition outcomes. These data have been linked to mental health data to assess the effect of specific service on arrest history.

- California Department of Health Care Services. The Commission receives data from the department twice yearly from a range of data sets, including information on mental health services, demographics and self-reported data on housing, employment, justice system involvement, hospitalization, health status, substance abuse, and related issues.

- California Department of Public Health. The Commission receives birth and death records from the California Department of Public Health. Data linked to death records include cause of death, ethnicity, race, age, sex, marital status, level of education, military status, and related information. The birth files includes age, race, ethnicity of parents, sex of child, gestational age, labor or pregnancy complications, and prior pregnancy loss.

- California Employment Development Department. The Commission receives quarterly wage data from the Employment Development Department.

The Commission is working to establish data sharing agreements in the following areas:

- Department of Health Care Access and Information. The Commission is negotiating a data use agreement to access data on hospitalizations to improve understanding of how involuntary treatment tools and related strategies result in hospital utilization.

- California Department of Public Health. The Commission is negotiating expanded access to public health data, including vital statistics data to improve its capacity to understand maternal mental health needs, suicide risks and rates, and related inquiries.

- California Department of Justice. The Commission is negotiating access to additional data held by the Department of Justice to explore trends in court rulings related to Incompetent to Stand Trial determinations and how those rulings are related to issues such as access to early care for psychosis, participation in FSPs, and racial and ethnic disparities.

- California Department of Social Services. The Commission plans to initiate a data sharing agreement with the Department of Social Services to improve understanding of the mental health needs of children and adults receiving social and protective services.

MHSOAC RESEARCH AND EVALUATION:

ACTIVITIES SUMMARY & GUIDE

The Commission promotes opportunities for prevention and early intervention, addresses disparities, and supports improved outcomes by analyzing data, conducting research and evaluations, and engaging experts – including diverse community members – to produce information and recommendations that inform policymakers and practitioners.

The Commission has five primary research and evaluation activities that are strategically designed to increase public understanding and reduce stigma, document the impact of existing policies and programs, provide the information required for robust community involvement and continuous improvement in services and outcomes, and to inform the Commission's agenda.

Within each of the five primary activities are current projects and activities supporting them, ultimately helping to achieve the Commission's strategic goals for transformational change. The strategic goals are comprehensive and robust:

Advance a Shared Vision

Advance Data, Analytics and Opportunities to Improve Results

Catalyze Improvement in Policy and Practice

RESEARCH AND EVALUATION DIVISION ACTIVITIES

TRACKING COMMUNITY INDICATORS

- Mental health funding
- Suicide incidence and rate
- Criminal justice/ mental health demographics and outcomes
- Numbers served in county mental health programs
- Participation in Full Service Partnerships
- Disparities in access to services

CURATING MENTAL HEALTH RESOURCES

- Documenting county innovation projects
- Building a prevention and early intervention dataset

POLICY RESEARCH TO IMPROVE POLICIES AND PRACTICES

- Embracing school mental health
- Enhancing criminal justice diversion
- Creating fiscal accountability
- Supporting prevention and early intervention
- Getting to zero in suicide prevention
- Promoting workplace mental health

EVALUATING NEW INITIATIVES TO ACCELERATE LEARNING, ADAPTATION, AND SCALING

- Mental Health Student Services Act
- SB 82/Triage Crisis Services
- Mental Health Innovation Incubator
- Full Service Partnerships

BUILDING DATA INFRASTRUCTURE TO SUPPORT ACCOUNTABILITY

- Mental health service utilization data
- Education data
- Employment data
- Criminal justice involvement data
- Child welfare data

AGENDA ITEM 3

Information and Discussion

Update on the Commission's Evaluation of S.B. 82/833 Triage Grant Programs

August 17, 2022 Research and Evaluation Committee Meeting

Summary: Commission staff and presenters will provide an update on the formative/process and summative evaluations of the Triage Grant programs, which will include a summary of community engagement, progress implementing the evaluation plan, preliminary findings and lessons learned and next steps.

Background: Evaluation of the Triage grant programs has been underway since 2019. The Commission contracts with UCLA and UC Davis evaluators to conduct the formative and process evaluations, while the Commission conducts the summative (outcome) evaluation.

At the September 1, 2021 Research and Evaluation Committee, Commission staff gave an update on the implementation of Round 2 Triage grants programs and presented a Summative Evaluation plan for evaluating outcomes. The Committee and members of the public discussed the methodological approach laid out in the Triage Summative Evaluation plan and endorsed moving forward. Committee and public feedback/recommendations were used to revise the Triage Summative Evaluation plan.

Today's presentations are designed to provide an update on the Commission's evaluation of the Triage grant programs and to elicit feedback from the Committee and public that the evaluators will use to inform their data collection, analyses and reporting.

Established by Senate Bill 82 in 2013, the Investment in Mental Health Wellness Act was signed into law by Governor Jerry Brown in June 2013. It provides grant funds to improve access to and capacity for mental health crisis services. The Triage grant program provides funds to California counties to increase crisis intervention, stabilization, treatment, rehabilitative services, and mobile crisis support teams. Supported services reduce costs associated with expensive inpatient and emergency room care, reduce incarceration, and better meet the needs of people experiencing mental health crises in the least restrictive manner possible.

Presenters: Corey O'Malley, PhD, Postdoctoral Researcher, Semel Institute for Neuroscience and Human Behavior, UCLA
Mark Saville, PhD, Assistant Professor, Department of Psychiatry, UC Davis
Kallie Clark, PhD, Triage Evaluation Project Director, MHSOAC

Agenda Item #3: Update on the Commission's Evaluation of SB 82/833 Triage Grant

Enclosures (3): (1) Executive Summary: Formative/Process Evaluation of Triage Child and School-County Collaborative grant programs; (2) Executive Summary: Formative/Process Evaluation of Triage Adult/TAY grant programs; and (3) Triage Summative Evaluation Data Update.

Handout (1): PowerPoint presentation.

Breakout Groups: After the Triage evaluation presentations, the Committee and public members will self-select a breakout group they would like to participate in. Each breakout group will be co-facilitated by a presenter and a Commission staff who will guide the discussion. Below is a list of questions unique to each breakout group that the evaluators have developed for the Committee and public members to consider and respond to.

Overarching questions for all breakout groups to consider include:

- How can the Commission ensure that the Triage evaluation findings are meaningful and actionable?
- How can the evaluation findings best be leveraged to inform local programs and state policy?

Group 1: Formative/process evaluations of Triage Child and School-County Collaboration programs (UCLA)

Background: The formative/process evaluations of the Triage Child and School-County Collaboration programs have been underway since 2019 (prior to the pandemic). The UCLA evaluators are in the final phase of data collection and analyses. A first in a series of evaluation reports will be due to the Commission in March 2022. The following questions will help them refine their data collection, analyses, and/or reporting.

- What priority areas should we focus on as we refine our findings? Are there areas of particular concern that should inform our final interpretation and reporting of findings?
- What considerations or concerns relevant to community mental health services are we missing? Are there additional factors we should investigate or incorporate into our existing findings?
- What policy considerations and concerns should inform the final stages of this formative evaluation?

Group 2: Formative/process evaluations of Triage Adult/TAY programs (UC Davis)

Background: The formative/process evaluations of the Triage Adult/TAY programs have been underway since 2019 (prior to the pandemic). The UC Davis evaluators are in the final phase of data collection and analyses. A first in a series of evaluation reports will be due to the Commission in March 2022. The following questions will help them refine their data collection, analyses, and/or reporting.

- We will be recruiting law enforcement partners who have collaborated with the SB-82 funded crisis triage programs in the final round of interviews. Do you have any guidance/thoughts around how we can approach in the best way possible?

Agenda Item #3: Update on the Commission's Evaluation of SB 82/833 Triage Grant

- It appears many of the programs are winding down after the grant ends. What avenues can programs consider to support the sustainability of these services? As evaluators, what questions should we be asking in this area?
- As the UC Davis, UCLA, and Commission research teams continue to work collaboratively, how can we as the formative evaluation team best support the summative evaluation team? What contextual factors should we be collecting to inform the interpretation of the summative findings?

Group 3: Summative evaluation of Triage Adult/TAY and Child programs (Commission)

Background: Commission staff presented the Triage Summative Evaluation plan to the Research and Evaluation Committee on September 1, 2021, which resulted in the Committee's endorsement. The goal of the Commission's analysis is to compare clients who receive Triage services to clients who receive non-Triage, crisis mental-health services (non-Triage) in the State of California. To do this, we will need to ensure that our groups of Triage and non-Triage clients are similar enough to compare. The first step in this process, is to calculate how likely each client is to receive Triage services (called a propensity score), and then use that information to create balanced groups. Then we check that our approach worked by comparing Triage and non-Triage groups along a number of characteristics. If the groups are similar along key characteristics, after balancing, then we can feel confident comparing the two groups. There are several things to consider in this process, and we would value your feedback on the following questions:

- What factors might impact whether someone receives Triage services versus non-Triage, crisis mental-health services?
- What client characteristics would you want to compare, between Triage and non-Triage clients, to determine if the two groups are similar?

UNIVERSITY of CALIFORNIA, LOS ANGELES

CENTER for HEALTH SERVICES and SOCIETY

California State Evaluation and Learning Support (Cal SEALS) for SB 82 Triage Grants

Executive Summary

Midpoint Progress Report on Formative Evaluation of Child/Youth and School-County Collaborative Programs

PREPARED FOR:
Mental Health Services Oversight and Accountability Commission (MHSOAC)

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November 17th, 2021

Executive Summary

Overview

This report summarizes the first two years of a formative evaluation of ten Child/Youth and four School-County Collaborative Triage programs receiving Triage Grants under the California Investment in Mental Health Wellness Act of 2013 (SB-82/833). The purpose is to provide **an early understanding of the processes involved in implementing these programs over time**, from program start-up through mid-2021. Findings in this report are based on analyses of multiple rounds of interviews conducted with individuals involved in program implementation, supplemented by program survey data, and informed by a wide breadth of program and community partners.

Mental health triage programs are intended to expand crisis services in their communities by providing personnel to assess and meet the needs of individuals and families experiencing mental health crises in the least restrictive manner possible. Overarching goals for SB-82/833 Child/Youth Triage Grants include expanding crisis prevention and treatment services, increasing client wellness, decreasing unnecessary hospitalizations and associated costs, and reducing unnecessary law enforcement involvement and costs. For SB-82/833 School-County Collaborative Grants, goals include increasing access to a continuum of mental health services and supports through school-community partnerships, developing coordinated and effective crisis response systems on school campuses, engaging parents and caregivers in supporting their child's social-emotional development and building family resilience, and reducing the number of children placed in special education or removed from school and community due to their mental health needs.

The Child/Youth and School-County Collaborative programs discussed here began operating between October 2018 and November 2020. These programs vary in their characteristics because they are tailored to the existing service systems in their respective counties and the specific needs of their communities. Six programs are housed in schools or school wellness centers, four are located at a program or county mental health office, two are primarily mobile crisis teams in the field or community, one is housed in an emergency department, and one is housed in a police department. Within these settings, programs vary in their relationship to their existing service systems: seven programs constitute new units within their service system and seven programs augment (or expand) an existing unit within their service system. Consistent with their mandate to provide crisis triage, these programs also provide a wide array of mental health care processes including prevention, early intervention, acute crisis services, treatment, referral, care coordination, and community outreach. Acute crisis services, referrals, and care coordination are the three most common care processes, and each are targeted by the majority of programs. Six of fourteen programs also target prevention, early intervention, treatment, and/or community outreach. Most programs target at least three care processes, with programs based in schools especially engaged in integrating multiple types of care processes.

Over the last two years, SB-82/833 Child/Youth and School-County Collaborative programs continually adapted to the ever-changing needs of their communities as well as the unique challenges posed by the COVID-19 pandemic. Programs' ability to flex and develop innovative solutions to deliver crisis triage services that are tailored to their communities demonstrate how heterogeneity across programs can be necessary and advantageous.

Aims and Methods

The specific aims of this formative evaluation are:

1. To **describe and assess select program implementation activities, processes, and outcomes** over time while accounting for variation in programs as well as the impacts of the COVID-19 pandemic.

2. To **identify facilitators and barriers to program** implementation over time.

3. To **provide lessons learned and evidence-based recommendations** for future program implementation.

To accomplish these aims, we use a **mixed methods approach** which focuses on the analysis of qualitative data, with quantitative data used to enrich our qualitative findings. Our evaluation activities also follow a **community-partnered approach**, emphasizing engagement and collaboration with the individuals involved in program implementation as well as a breadth of community partners. Our framework for meeting these aims is also **informed by insights from implementation science**, especially the Consolidated Framework for Implementation Research (CFIR; Damschroder et al., 2009), which identifies five major domains that affect program implementation:

- **characteristics of the program**
- "**outer setting**" of external county and community context
- "**inner setting**" of the organization or agency that operates the program
- **characteristics of the individuals** involved in program implementation
- **processes** and strategies used to implement the programs

Building further from the insights of implementation science, we also address specific effects of these processes—known as implementation outcomes—such as the extent to which the programs are perceived as satisfactory or the extent to which programs can be executed successfully. Together, this approach leverages advances in implementation science and community-partnered research.

Data

Our primary data sources are qualitative interviews of program leads and their staff and surveys of program leads. Data and insights are also drawn from a variety of engagement activities following our community-partnered approach. Data collection for these data sources is explained in the following sections.

Interviews

Interviews with individuals involved in the implementation of each program were conducted every six months beginning in mid-2019. Interview guides for each round of interviews were developed to address specific factors from the Consolidated Framework for Implementation Research as well as evolving contexts such as the COVID-19 pandemic. This strategy of repeated interviews allows us to capture dynamic change over time, incorporate multiple individuals' perspectives on implementation, and address a variety of factors that affect program implementation. The table below summarizes the timing of and participants in the four rounds of interviews analyzed in this report. Each interview includes one or more individuals involved in implementing a given program and every program is

represented in each round of interviews. For two counties with both a Child/Youth and a School-County Collaborative Grant, a single baseline interview was conducted with leads for both programs.

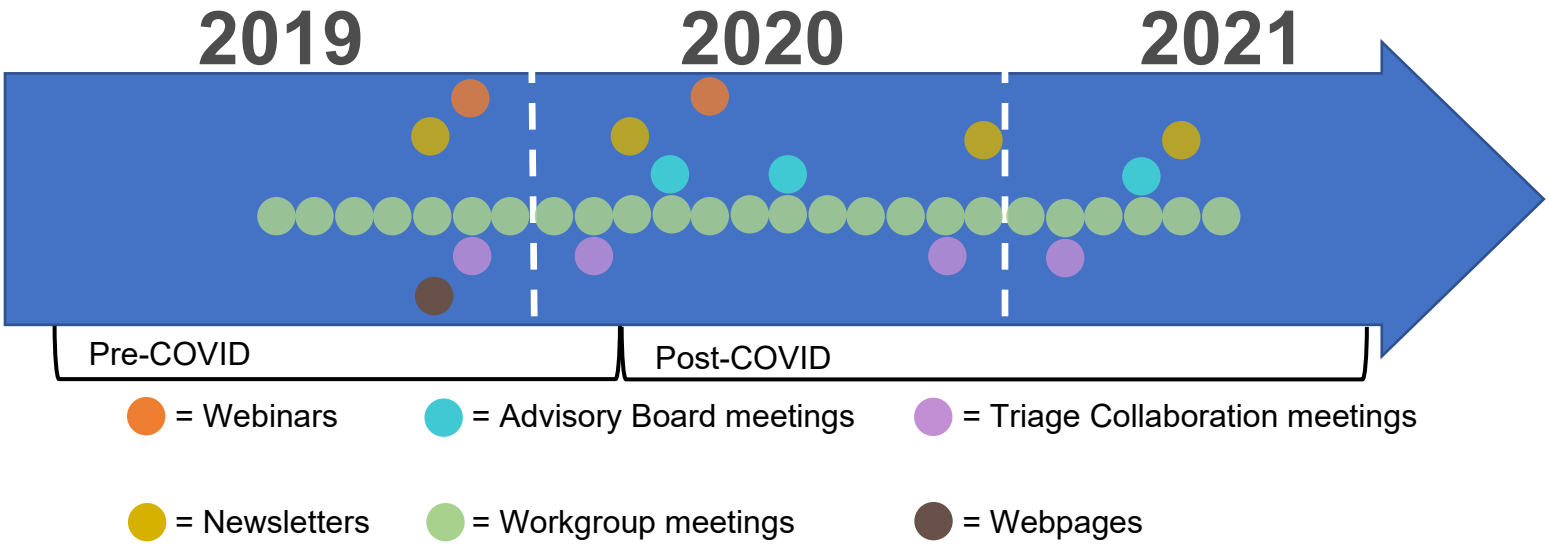
	Pre-COVID Closures		Post-COVID Closures	
	Baseline	**6-month**	**12-month**	**18-month**
Dates	June–Sept 2019	Jan–Feb 2020	June–Oct 2020	Feb–Apr 2021
Participants	Program Leads	Program Leads	Program Staff	Program Leads
# of Interviews	12	14	14	14

Program Surveys

To supplement qualitative interview data for the mid-point report, a program lead survey was conducted in mid-2021 to capture program leads' attitudes toward factors related to program implementation, the suitability and effectiveness of their programs for addressing Triage Program goals, and activities related to funding, revenue, and sustainability. A primary administrative lead from each of the fourteen programs completed this survey.

Engagement Activities

Collaboration with county and program partners and other engagement activities have continuously informed our progress in meeting the aims of the evaluation. The evaluation has benefitted from the contributions and input of approximately 175 collaborators, including individuals involved in program implementation, community partners, expert advisors, and members of the public. We engaged collaborators through webinars, newsletters, advisory board meetings, three regular workgroups, Triage Collaboration meetings, and the development of a webpage. The figure below visualizes the timing of these engagement activities between mid-2019 and the evaluation mid-point in 2021.



Analysis

Interview transcripts and notes from engagement activities were thematically analyzed by the evaluation team using mixed methods data analysis software. A codebook of important themes was developed using the evaluation framework, interview guide, SB-82/833 Triage Grant Program goals,

and priority issues identified by our collaborators, with additional themes added to the codebook during review of the data. Evaluation staff coded the qualitative data by applying thematic codes to appropriate excerpts and then examined the thematically coded excerpts to identify common barriers to and facilitators of implementation.

Data from the program lead survey were also cleaned, formatted, and analyzed to produce descriptive tables to supplement the thematic findings.

Preliminary Findings

Program Characteristics

Program characteristics are the features of a program that might influence how it is implemented. This includes descriptive characteristics of the programs and their components, such as the service settings in which they operate, the care processes and services they provide, program timing and maturation, and the level of grant funding they received. Other important characteristics directly relate to their suitability for implementation, such as how complex the program's structure is or how adaptable its components are.

SB-82/833 programs are very **heterogeneous** in their primary settings, care processes, timing and maturation, and amount of grant funding received. This heterogeneity is explained primarily by **tailoring of the programs** to the existing mental health and social service systems in their respective counties.

Funding cuts impacted early program implementation resulting in some **reductions** to the volume and type of services, number of sites, mix of staff roles, and number of geographic units that programs could serve. Funding cuts also increased the in-kind, often hidden, contributions implementing organizations made to ensure that their programs could be executed successfully.

Programs are **highly adaptable**, especially evident during the COVID-19 pandemic. The greatest barriers to adaptability relate to areas where programs **lack access to resources**, including funding, adequate organizational budgets, and community assets, or where barriers to implementation are **beyond the authority of the program** to address. For some programs, strong organizational partnerships mitigate these challenges.

Outer Setting

The **outer setting** of program implementation refers to the external contexts that might influence implementation, including the impact of global, national, or local conditions and events. This can include how programs respond to (and interact with) the conditions in their community and county—including available assets and needs of the community, and how the implementing organizations are connected with other organizations in the county. This can also include larger-scale social forces with an impact on program operations, such as the COVID-19 pandemic.

Programs are **tailored to the specific needs** of their communities, both in design and in the types of adaptations made over the course of implementation. Areas of particular concern and attention include the need for dedicated child mental health services as well as need for culturally appropriate

care, especially for minoritized racial and ethnic communities, and need for care that is responsive to structural racism within communities and social service systems.
SB-82/833 programs partner and coordinate with a wide number of organizations and agencies in different sectors and at multiple levels, either due to their formal structure, by practical necessity, or as an intended outcome. A common intention is for partnerships to have a **long-term impact on linkages across sectors**, either by creating and sustaining durable formal partnerships, enabling practical cross-sector workflows, and/or creating better integrated social service systems.

SB-82/833 programs experience **barriers to implementation** when community assets for mental health, such as child psychiatric hospital beds, crisis stabilization units, crisis residential facilities, and even outpatient clinics and providers, are not available in-county or adequate to support effective crisis care.

The **COVID-19 pandemic** constituted a major context in which program implementation must be understood, leading to observed changes in community needs (such as greater and more severe mental health needs and an increase in basic needs) as well as changes in program demand and referral sources. Programs made **extensive adaptations and innovations**, including rapid uptake of telehealth, with mixed perspectives on its utilization and efficacy. Other innovations were also developed to address a variety of challenges including disruptions to program settings, referral sources, youth and family engagement, and in-person team coordination. Despite innovations, teams also experienced durable challenges including strain on their staff, lost time continually re-adjusting to an ever-changing landscape, new barriers to building and sustaining partnerships, increased uncertainty around future funding, and loss of access to critical resources.

Inner Setting

The **inner setting** of program implementation refers to features of the implementing organization that might influence implementation, including its organizational characteristics, culture and climate, and the extent of leadership engagement in the program. This involves how SB-82/833 programs operate within their organization(s), including how they coordinate, how the program fits with the goals and workflows of the organization, and how readily SB-82/833 services and staff are integrated into the organization and supported by leadership.

SB-82/833 programs are generally closely embedded in the organizations that implement or house them. **Programs coordinate closely with other units** in their organizations to deliver their services, fill gaps in their social service systems, share limited resources, and generally increase the capacity of their crisis care systems. A major challenge to this integration is **staff turnover and gaps**, which impacted many programs by changing the services they can provide, placing additional burden on remaining staff, and reducing programs' institutional knowledge and networks. Contributors to staff turnover include stresses related to the nature and structure of dedicated crisis roles, prevailing public sector mental health compensation, and work conditions. Some programs also experienced related **challenges in recruiting and hiring staff**, with additional challenges including hiring for short-term positions, provider shortages (both regional and linked to licensure requirements), and delays related to the COVID-19 pandemic. Smaller and more rural challenges experienced special challenges relating to both retaining and hiring staff.

Programs **generally fit well within their organizations' existing missions and workflows** and feel adequately prioritized by their organizational leadership. Programs that are housed in external organizations (e.g., schools, hospitals, police departments), however, have varying experiences ensuring that they are properly aligned with and prioritized within these settings. While many

programs report successes, some describe extensive work to ensure that their programs are successful within these settings. While such efforts are also a major contribution (indeed, goal) of programs, they take more time and resources to achieve depending on the particular site.

Programs report good support in terms of access to resources within their implementing organizations but note that such resources are heavily constrained in mental health systems. Organizations provide extensive support in the form of additional personnel for administration and data coordination, but programs report that the **resources needed often exceed the capacity of their organization** to supply. These challenges are especially **acute for smaller and more rural counties**.

Individual Characteristics

Individual characteristics are factors related to the particular individuals who are involved in implementation, most notably the leadership and staff of the programs. As such, we sought to explore characteristics of the individuals integral to implementing services, including their attitudes and level of engagement.

Although program staff work under challenging conditions due to their workloads and the nature of crisis work, they generally express **positive attitudes** toward program quality, as well as **passion and enthusiasm** for their work despite challenges. Program leads have positive impressions of their staff, emphasizing their **dedication and skills**.

Many staff go **above and beyond** to ensure the success of their programs. For some programs, this may also include heavy reliance on a **single champion** or extensive engagement from **staff not funded** by the SB-82/833 Triage Grant program.

Implementation Processes

Implementation processes are the processes and strategies that are carried out in program implementation, such as efforts to incorporate stakeholder input into planning, the extent to which staff “champion” the intervention, and the extent to which the intervention is carried out according to plan.

Most programs felt that **adaptations allowed them to generally execute the programs** they had intended. The biggest barriers to accomplishing this they identified were the **COVID-19 pandemic** and **limited resources**, with some programs also experiencing delays related to establishing critical partnerships.

For many programs, **data collection and reporting constitute a significant burden** that is linked to **access to resources** (especially staff capacity), differences in the quality of county and site data infrastructure, organizational and regulatory challenges, as well as complications from the pandemic.

Since grant support for programs varies, multiple programs describe efforts to **“patchwork” additional funding** or revenue to support their ongoing operations, including through Medi-Cal billing, other MHSA funds, county and community funds, and other grants. Across the 14 SB-82/833 programs, an **average of 2.3 funding sources were reported to supplement** Triage Grant funding. Programs also described efforts toward sustainability planning. Among the nine SB-82/833 programs with a sustainability plan in place, an **average of 3.2 funding sources were reported**. Both patchworking and sustainability planning required significant effort and confronted durable and systemic challenges related to the lack of options for adequate, predictable, and reliable support for

mental health services.

SB-82/833 Triage Program Goals

SB-82/833 programs engage in a variety of activities that both address and fit with the goals of the Triage Grant Program. While Child/Youth programs and School-County Collaborative programs have some distinct Triage Grant goals, many Child/Youth programs show evidence of addressing School-County Collaborative grant goals and vice versa, attesting to the wide range of potential impacts of these programs on child mental health crisis systems.

Expand crisis prevention and treatment services:
Programs address expanding crisis prevention and treatment services by filling gaps in services systems and settings, identifying and responding to unmet community needs including those of underserved communities related to crisis services, and engaging in partnerships for improved linkage and utilization. Program leads in 13 programs agreed that their SB-82/833 activities and services are suitable for and effective at addressing needs that were not adequately met by other mental health programs in their county of community.

Increase client wellness:
Programs address increasing client wellness by providing crisis services that are targeted to the specific mental health needs of their communities. Program leads and staff work to ensure their operations are aimed at improving mental health outcomes and overall wellness. The majority of program leads in 13 programs agreed that the activities and services of their SB-82/833 program are both suitable for and effective at increasing client wellness.

Decrease unnecessary hospitalizations and associated costs:
Programs address decreasing unnecessary hospitalizations and associated costs by providing preventative care aimed at reducing the incidence of mental health crisis, providing early intervention services aimed at identifying needs or crises before the escalate to the point where hospitalization is considered, providing crisis services that improve the quality of crisis response to de-escalate, providing age-appropriate crisis services that improve the quality and depth of child crisis response to de-escalate crisis situations, and addressing unnecessary use of emergency departments for mental health crises.

Reduce unnecessary law enforcement involvement and costs:
Programs address reducing unnecessary law enforcement involvement and costs by providing parent trainings, preventive crisis services, social-emotional learning, and other supports to prevent the need for law enforcement involvement; providing a law enforcement alternative when mental health crises occur; improving law enforcement's understanding of mental health; and providing options for co-response with law enforcement to promote de-escalation.

Increase access to a continuum of mental health services and supports through school-community partnerships:
Programs address increasing access to a continuum of mental health services and supports through school-community partnerships by offering services that did not previously exist in schools, increasing the reach and intensity of existing services, and utilizing a partnered approach to offer greater depth of care. Among the four School-County Collaborative programs, all agreed that the activities and services of their SB-82/833 programs are suitable for and effective at both addressing this goal and developing new or strengthening existing school-community partnerships for mental health.

Develop a coordinated and effective crisis response systems on school campuses when mental health crises arise:
Programs address this goal by providing capacity and coordination for new referrals and tracking systems both prior to and during the COVID-19 pandemic, providing resources and support to ensure existing systems are used appropriately and effectively, and using referral systems to ensure major crises in schools are addressed timely and appropriately. Among the four School-County Collaborative programs, all agreed the activities and services provided by their SB-82/833 programs are suitable for and effective at addressing this goal.

Engage parents and caregivers in supporting their child's social-emotional development and building family resilience:
Programs address this goal by providing outreach, training, support, and resources to parents/caregivers beyond immediate interactions during discrete crises. Among the four School-County Collaborative programs, all agreed the activities and services provided by their SB-82/833 programs are suitable for and effective at addressing this goal.

Reduce the number of children placed in special education for emotional disturbance or removed from school and community due to their mental health needs:
Programs address this goal by tracking special education utilization and school discipline to understand how and when they may be disproportionately used for minoritized students or students with mental health needs, working with school staff in special education to improve knowledge and access to resources, and working with school staff to improve systems and cultures in school discipline before the COVID-19 pandemic. Among the four School-County Collaborative programs, two agreed the activities and services provided by their SB-82/833 programs are suitable for and effective at addressing this goal.

Implementation Outcomes

Implementation outcomes are the impacts of implementation processes, and include program acceptability, appropriateness, feasibility, fidelity, penetration, and sustainability.

Program **acceptability**, the extent to which the service or program is perceived by leads and staff as satisfactory, is generally high with few major challenges to acceptability identified in the present findings. Challenges related to the limits of program adaptability and strain on program staff are presently among the most likely barriers to acceptability.

Program **appropriateness**, the relevance or fit of the service or program to a given context, is generally high, as programs are tailored to their settings and fit with their implementing organizations or work to overcome challenges in fit with partners in other sectors. A potential barrier to appropriateness concerns the extent to which sustainability planning may transition SB-82/833 programs to funding sources that reduce their ability to provide services that are well-tailored to their community needs and the gaps in their existing service systems, especially with respect to preventive care and universal interventions.

Programs are generally feasible in principle, but face some barriers to **feasibility** in their execution, especially for programs that are complex and highly networked. The biggest barriers to feasibility for SB-82/833 programs, therefore, concern the availability of necessary resources (including funding), access to critical community assets for mental health, and access to sufficient staff. Major factors that offset these challenges and thus made programs feasible—indeed possible—to deliver are the adaptability and high level of engagement of many program leads and staff.

Fidelity is the extent to which services and programs are executed successfully by the particular implementing organization or service setting. Most programs felt that adaptations made over the course of implementation allowed them to deliver their intended services and address their intended aims, even as the specifics of execution varied from what had been expected prior to the pandemic.

Programs vary in their **penetration**, that is, the level and type of integration with their organizations, especially for programs set in non-mental health settings. The biggest barriers to integration in these settings are the extent of external leadership buy-in and administrative capacity for partnerships, which were mitigated by SB-82/833 staff and leadership engagement.

Major facilitators of program **sustainability**, the extent to which the program is or can be maintained over time, include their **adaptability**, the extent to which they are **adequately prioritized** by their implementing organization(s) and **supported by leadership** in their organizations. The most impactful barriers to program sustainability, however, center on resources. Program **sustainability will be low to the extent that programs lack stable resources** necessary to sustain their operations on an ongoing basis or are unable to secure adequate, predictable, and reliable alternative sources of funding and revenue.

Early Lessons Learned

1. SB-82/833 programs make noteworthy contributions to mental health services in their counties and communities.
   - Programs are designed and implemented to **increase access** to mental health services for children and youth.
   - SB-82/833 programs are taking actions to **improve the quality** of mental health crisis services for children in their communities.
   - SB-82/833 programs **expand mental health and crisis services in schools**.

2. Some major advantages of SB-82/833 programs—including operation across multiple care processes on the crisis continuum, integration with teams both in and outside of their organizations, and partnerships across sectors—also make them more challenging to deliver. Programs would likely benefit from support directed toward these unique advantages and their corresponding challenges.
   - Given programs' level of specialization, complexity, involvement in partnerships, and tailoring to community needs, they may benefit from **more time to design, plan, and ramp up their programs prior to the start of service delivery** as well as support during this time to ensure that major barriers can be overcome.
   - **Additional administrative resources may be appropriate** to support extensive, ongoing coordination between organizations to promote success.
   - Given their heterogeneity and wide scope of activities, programs are likely to benefit from **flexibility in how their programs are designed and executed** to ease their efforts aligning contractual obligations with the needs of their communities, implementing organization, staff, and partnered organizations.
   - Programs would likely benefit from **additional support for developing effective partnerships in sectors relevant to their programs**. To the extent that specialized resources for support do not already exist, programs would likely benefit from access to venues to develop and share best practices for partnering with emergency departments/hospitals, police departments, schools.

- Formalized partnerships may be most appropriate when initiated organically and tailored to need rather than administratively/bureaucratically mandated.

3. SB-82/833 programs face **challenges in ensuring that they have access to adequate resources** to allow them to implement their programs and focus on program goals without straining their personnel.
   - Programs are likely to benefit from **increased clinical and other service staffing** to make workloads more manageable and reduce the likelihood of staff burnout.
   - SB-82/833 program implementation would likely benefit from **access to more robust community assets for child mental health in their counties**, such as youth psychiatric inpatient beds, crisis stabilization units, crisis residential programs, mental health urgent care clinics, and outpatient treatment resources.
   - Programs would likely benefit from more **stable, predictable, and long-term funding opportunities**.
   - Where programs would benefit from more resources than are immediately available, programs may need more **learning opportunities to increase their capacity to close resource gaps**.
   - To the extent that resources for child mental health services remain scarce relative to need, it may be advantageous to **ensure that grant-funded programs are appropriately scaled to the resources available**, especially if funding is reduced.

4. Especially given limited staffing and resources and the inherent challenges of crisis work, SB-82/833 program implementation would benefit from **support to develop strategies to reduce or mitigate staff turnover**.
   - Many programs would benefit from more **systematic efforts to assess staff workload, detect signs of burnout, and work with staff to address issues** before they progress. Many programs would also benefit from ensuring that remuneration for positions is competitive, which may involve action at the county level.
   - Since some amount of turnover in staff is inevitable (retirements, medical or family leave, etc.), programs would benefit from the **development of mechanisms to sustain resources, relationships, partnerships when staff turnover occurs**.

5. School-based programs, both Child/Youth and School-County Collaborative, have some special considerations that affect grant program design and program execution and should be addressed.
   - **School-based programs, in particular, may benefit from additional time between grant award and the expected start of services.** They may need to develop contracts and build relationships with school districts, hire staff in schools, establish a defined division of labor with existing school staff, or establish new workflows in schools. Programs would also likely benefit from time to plan their outreach efforts toward students and families.
   - **Alignment of grant funding with the school year** would ease implementation of school-based programs.
   - School-based programs may need additional **support developing strategies to navigate between the data and regulatory systems** that prevail in the mental health and educational sectors.

University of California, Davis
Behavioral Health Center of Excellence

California State Evaluation and Learning Support (Cal SEALS)
for SB-82 Triage Grants

Executive Summary

from

Midpoint Progress Report:

Formative/Process Evaluation of Triage Adult/TAY Grant Programs

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Agenda Item #3: Update on the Commission's Evaluation of SB 82/833 Triage Grant

Executive Summary

I. Background

The Mental Health Wellness Act of 2013 (SB-82) provides grant funds to improve access to and delivery of crisis triage services across California. These services focus on increasing capacity in crisis intervention, crisis stabilization, crisis residential treatment, rehabilitative mental health services, and mobile crisis support teams. The overarching goals are to better meet the needs of individuals in crisis in the least restrictive manner, and to cut costs through reduction of avoidable emergency department (ED) use, law enforcement involvement, and inpatient hospitalizations. A formative evaluation is needed to better understand the processes related to the crisis intervention program implementation under SB-82 and to obtain generalizable insights that will inform future crisis intervention program development in California. To do this, we used a mixed methods approach for the formative evaluation of the adult/Transitional Age Youth (TAY) programs funded by SB-82, applying a variety of qualitative and quantitative methods (see *Deliverable 4a: Revised Draft of Formative Evaluation Plan* for full details). We address seven key questions related to the implementation of the crisis programs to unveil insights, lessons learned, and contextualizing factors. This reports details preliminary results of the SB-82 adult/TAY formative evaluation.

The Adult/TAY team conducted preliminary analysis from multiple data sources, including two rounds of interviews with program providers – the first conducted in 2019 and the second conducted in 2021, a survey administered to program leaders including detailed questions about each county program, county MOUs secured with community partners, original county grant proposals along with revised program descriptions following budget reductions, county census data, and stakeholder engagement activities (e.g., meetings and webinars).

II. Summary of Findings

The formative evaluation was developed to address seven key questions. A summary of the main findings for each question is presented below.

Question 1: What is the structure of the programs that are being delivered and how does this compare prior to SB-82? The evaluation uses quantitative, county reported survey data and qualitative interview data and highlights a broad range of program structures across the SB-82 funded adult/TAY programs. Different programs have sought to address different components of the crisis continuum model, which includes prevention, the crisis stage, and the post-crisis follow-up (Appendix 1). It is also notable that different programs have attempted to address these individual components in unique county specific ways. The priority clustering of individual counties is highlighted in the evaluation below, along with a comprehensive description of the within and between cluster variation in approaches across county programs which is summarized in detail in Appendix 3.

Question 2: What are the key contextual factors that impact the implementation of the proposed programs? Through engagement with programs and broader key stakeholders, via webinars, SB-82 quarterly meetings, meetings with our stakeholder advisory group and interviews with counties, the evaluation identified key contextual factors that could potentially impact the implementation and

outcomes of the programs. These included: transportation infrastructure; population size and density; staff retention and burnout; total number of direct service providers in crisis care, local 5150 policy, characteristics of engagement with law enforcement and other agencies; continuity of care and the availability of additional resources to supplement the SB-82 program. In addition to considering the program structure, stakeholders reported it is critical for the statewide evaluation to consider these contextual factors in terms of their impact on implementation and program outcome.

Question 3: How successful have the programs been in establishing the required MOUs with county partners? A review of MOUs signed by the county with SB-82 program partners and qualitative data from interviews with county personnel informed this analysis. Overall, only 33.3% of programs reported executing a MOU with a community agency specific to SB-82 funded activities. However, the ability to effectively collaborate with communities was not considered to be contingent on a formalized agreement for many programs. Principal facilitators to effective collaboration with community partners included developing mutually beneficial partnerships, the importance of developing interpersonal relationships across management levels, having prior relationships and knowledge of community partners, developing trust, and continued effective communication.

Question 4: How successful have the programs been at recruitment, training, and retention of the providers required to deliver the services? This question was addressed by review of county hiring reports, quantitatively using data from responses to the county program survey, and through qualitative interviews with county personnel. Many programs reported significant challenges around recruitment of clinicians. However, hires that were a good fit for crisis services were easier for programs to retain, despite significant concerns around burnout and the associated challenges with crisis work. Some programs were evaluating compensation differentials as a means to address the unique demands of crisis care and reduce turnover proactively. Most programs had active plans in place for adjusting to turnover. Amongst the programs utilizing peer specialists, most indicated they found it easier to recruit peers, but peer staff turnover was higher. Regarding training, interviewed participants identified different needs across programs, such as additional training in substance use disorders and harm reduction approaches, additional risk assessment and safety planning training, motivational interviewing techniques, additional diversity training, CBT and DBT approaches, training in sex-trafficking, solution focused therapies, and in trauma-informed approaches. Due to significant variation, the findings highlight the importance of supervisors and managers engaging with frontline providers directly to identify training needs.

Question 5: How many consumers have received what types of services over time? Is this consistent with the proposed activities? The evaluation team surveyed thirteen SB-82 grantees to collect quantitative data on clients served and services provided. Surveyed SB-82 programs experienced steady growth in utilization over time, with seven of thirteen meeting or exceeding the expected annual number of clients within the first year. These thirteen grantees provided over 41,000 services during 13,450 encounters with 9,143 individual clients as of December 31, 2020. About half the services provided by SB-82 grantees were case management services (46%), followed by outreach and engagement services (19%) and assessment services (10%). SB-82 programs served clients of all ages – children, TAY, adults, and seniors. Overall, the proportion of clients identifying

as female was similar to that of males. SB-82 programs also served clients who reported other gender identities. SB-82 programs served a diverse population of clients, which largely reflected the demographics of the counties in which they are located. SB-82 programs primarily provided case management, outreach and engagement, and assessment services. In 2020, however, utilization of outreach and engagement and case management services decreased significantly in many SB-82 programs, attributable to pandemic-driven changes in care. While utilization of some services did fall substantially, service across most SB-82 grantees and the number of clients served per quarter by SB-82 programs did not fall significantly as a result of the pandemic.

Question 6: What are the early impacts of these programs on the proposed outcomes? The evaluation used a semi-structured qualitative interview conducted with current and previous SB-82 program providers. From the perspective of these providers, the SB-82 crisis services had a substantial positive impact on key primary outcomes. Depending upon the program and its structure, these included reductions in psychiatric hospitalizations; reduction in evictions, homelessness, and suicides; reduced ED and law enforcement involvement in crisis care; improved client and community-level satisfaction in behavioral health crisis care; and improvements in key recovery outcomes. Outside of the primary outcomes, participants emphasized the importance of relationship building with individuals typically highly ambivalent about behavioral health services, which can help address stigma towards services, and can later lead to engagement in care.

Question 7: What are the barriers and facilitators to successful implementation of the proposed programs? Program participants in the semi-structured interview identified a number of key barriers and facilitators to effective program implementation. Different barriers were identified at the client-, program-, and broader system-wide level, with a range of different potential solutions proposed for each. Facilitators to effective crisis care included the importance of the client's support system; the empathetic, patient-oriented approach of the providers; availability of resources to deliver effective field-based care; and the structure of the crisis program, including the importance of extended hours of operation, being present in the community, the team approach to crisis service delivery, and a critical role for peers in service delivery. Unsurprisingly, COVID-19 was identified as a substantial barrier to effective program delivery. To mitigate its impact, many programs reported switching to deliver services via phone or video teleconferences. While telehealth has its unique challenges, delivering services in this fashion was reportedly far more successful than providers expected, and as a result many have considered adopting a hybrid model once the pandemic is over.

Ten of thirteen grantees said they plan to continue their SB-82 programs after SB-82 grant funds expire, while three grantees said it isn't a priority to continue their SB-82 program or services. Grantees that plan to continue their SB-82 program or services are considering a range of sustainability strategies. These range from utilizing alternative funding sources such as billing Medi-Cal or pursuing additional MHSA funding, to restructuring their SB-82 program or other services by reducing staffing, redistributing existing funding sources, or consolidating the services offered by their SB-82 program into existing programs.

III. Conclusions

The findings of this preliminary formative evaluation provide a promising early indication of the beneficial impacts of the SB-82 triage program and document the provision of services to a large

number of clients across the state in the face of significant challenges provided by the COVID-19 pandemic. Importantly, they suggest that the SB-82 triage programs have had a positive impact on multiple key outcomes related to the goals of SB-82. These findings also identify a number of barriers and facilitators to effective crisis care delivery. These findings could be highly informative both to new programs attempting to understand the optimal service structure, and to support quality improvement efforts of established programs. Going forwards, additional data from programs, clients, and community partners will be critical to better understanding the ultimate impact of these programs. Despite the substantial challenges brought by COVID-19, the subsequent shelter in place mandate, and the challenges many programs have faced recruiting clinical staff, almost all programs have been successful in providing a broad range of crisis services to many of the county residents they serve.

Mental Health Services
Oversight & Accountability Commission

Triage Summative Evaluation Data Update

Research and Evaluation Committee Meeting: Supplementary Materials

August 17th, 2022

Agenda Item #3: Update on the Commission's Evaluation of SB 82/833 Triage Grant

Table 1

Target Age Group Served by County

Counties with Programs Serving:	Triage Clients
Adults only	
Alameda County	1730
Butte County	347
Merced County	3334
San Francisco County	83
Sonoma County	118
Tuolumne County	207
Ventura County	3026
Total	8845
Children only	
Riverside County	2331
San Luis Obispo County	237
Santa Barbara County	397
Total	2965
Both adults and children	
Calaveras County	322
Humboldt County	1605
Los Angeles County	3281
Placer County	704
Sacramento County	749
Stanislaus County	908
Yolo County	322
Total	7891

Data source: Triage program data provided by counties.

Notes: Anyone under 16 is classified as a child. Anyone 16 and older is classified as Adult/TAY. The data above do not include School-County collaboratives (of which there are four) and the City of Berkeley. A handful of clients are represented in both the child and adult/TAY data sets, as they initially signed up as children and then transitioned to adult programs.

Table 2

Number and Proportion of Adult Triage Clients by County

County		
Alameda	1730	12%
Butte	347	2%
Calaveras	208	1%
Humboldt	1281	9%
Los Angeles	2245	16%
Merced	3334	24%
Placer	231	2%
Sacramento	582	4%
San Francisco	83	1%
Sonoma	118	1%
Stanislaus	555	4%
Tuolumne	207	1%
Ventura	3026	22%
Yolo	118	1%

Data source: Triage program data provided by counties.

Notes: Anyone 16 and older is classified as Adult/TAY. The data above do not include School-County collaboratives (of which there are four) and the City of Berkeley. Sums may not equal 100% due to withheld data or rounding.

Table 3

Adult/TAY Triage Clients by Gender

County	Female	Male	Other	Unknown
Alameda	42%	58%	0%	0%
Butte	40%	57%	0%	3%
Calaveras	45%	55%	0%	0%
Humboldt	30%	53%	/	17%
Los Angeles	47%	53%	0%	0%
Merced	46%	53%	/	2%
Placer	49%	51%	0%	0%
Sacramento	46%	50%	3%	1%
San Francisco	43%	48%	0%	9%
Sonoma	51%	48%	/	/
Stanislaus	46%	48%	/	6%
Tuolumne	55%	45%	/	/
Ventura	56%	40%	/	/
Yolo	42%	58%	0%	0%

Data source: Triage program data provided by counties.

Notes: Gender identity is self-reported as collected by Triage service providers. Only values that exceed a threshold of 11 or more clients within a given county are reported for privacy and data integrity. "/" indicates categories that have been omitted due to small ns. Sums may not equal 100% due to withheld data or rounding.

Table 4

Adult/Tay Triage Clients by Race and Ethnicity

County	White or Caucasian	Black or African American	Hispanic or Latin(o/a)	American Indian or Alaska Native	Other	Unknown/Not Reported
Alameda	17%	28%	2%	/	11%	42%
Butte	61%	3%	12%	6%	/	16%
Calaveras	68%	/	/	/	/	22%
Humboldt	62%	2%	6%	8%	2%	20%
Los Angeles	14%	17%	30%	/	19%	20%
Merced	33%	9%	47%	2%	5%	3%
Placer	65%	/	10%	/	10%	11%
Sacramento	21%	29%	17%	/	7%	25%
San Francisco	12%	28%	39%	0%	20%	/
Sonoma	40%	/	/	0%	/	49%
Stanislaus	45%	0%	41%	/	6%	7%
Tuolumne	62%	/	6%	/	/	27%
Ventura	32%	3%	43%	1%	19%	2%
Yolo	32%	/	32%	/	/	27%

Data source: Triage program data provided by counties.

Notes: Only values that exceed a threshold of 11 or more clients within a given county are reported for privacy and data integrity. "/" indicates categories that have been omitted due to small ns. Sums may not equal 100% due to withheld data or rounding.

Table 5

Adult/TAY Triage Clients by Primary Language

County	English	Spanish	Other	Unknown / Not Reported
Alameda	61%	1%	1%	37%
Butte	87%	/	/	10%
Calaveras	84%	0%	0%	16%
Humboldt	79%	/	1%	19%
Los Angeles	86%	9%	2%	4%
Merced	91%	8%	1%	/
Placer	87%	/	/	12%
Sacramento	81%	/	/	19%
San Francisco	86%	/	/	/
Sonoma	91%	1%	0%	8%
Stanislaus	94%	6%	/	0%
Tuolumne	81%	0%	/	16%
Ventura	89%	8%	1%	2%
Yolo	86%	/	0%	13%

Data source: Triage program data provided by counties.

Notes: Only values that exceed a threshold of 11 or more clients within a given county are reported for privacy and data integrity. "/" indicates categories that have been omitted due to small ns. Sums may not equal 100% due to withheld data or rounding.

Table 6

Percent of Adult Triage Clients Ever in a Full-Service Partnership by County

County	Yes	No
Alameda County	20%	80%
Butte County	9%	91%
Calaveras County	23%	77%
Humboldt County	11%	89%
Los Angeles County	10%	90%
Merced County	7%	93%
Placer County	14%	86%
Sacramento County	20%	80%
San Francisco County	18%	82%
Sonoma County	0%	100%
Stanislaus County	7%	93%
Tuolumne County	13%	87%
Ventura County	5%	95%
Yolo County	41%	59%

Data source: Triage program data provided by counties.

Notes: Sums may not equal 100% due to withheld data or rounding.

Table 7

Percent of Adult Triage Clients Reporting SSN by County

County	Reported	Not Reported
Alameda County	4%	96%
Butte County	90%	10%
Calaveras County	77%	23%
Humboldt County	84%	16%
Los Angeles County	75%	25%
Merced County	0%	100%
Placer County	89%	11%
Sacramento County	71%	29%
San Francisco County	100%	0%
Sonoma County	19%	81%
Stanislaus County	93%	7%
Tuolumne County	0%	100%
Ventura County	79%	21%
Yolo County	97%	/

Data source: Triage program data provided by counties.

Notes: Only values that exceed a threshold of 11 or more clients within a given county are reported for privacy and data integrity. "/" indicates categories that have been omitted due to small ns. Sums may not equal 100% due to withheld data or rounding.